Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CROWN CHIROPRACTIC

Respondent Name
TEXAS SCHOOLS PROPERTY & CASUALTY

MFDR Tracking Number
M4-14-0425-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
October 03, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have billed $500.00 to the carrier for the service of impairment rating evaluation using the DRE system. They have reduced the bill to $221.29 and paid that amount stated that it is per fee schedule. We have resubmitted for reconsideration only to have the first finding being upheld. I contest that the fee schedule allows for $500.00 for this service. I have no contract with this carrier that would allow such a reduction."

Amount in Dispute: $278.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the DWC-69 submitted for the MMI/IR exam performed the claimants was set at clinical MMI on 8/7/13 with no permanent impairment as a result of the compensable injury.

- 28 TAC §134.204(j)(2)(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.
- 28 TAC §134.204(j)(3) The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. Reimbursement shall be the applicable established patient office visit level associated with the examination. Modifiers "V1, V2", V3", V4", "V5" shall be added to the CPT Code to correspond with the last digit of the applicable office visit. "

Response Submitted by: JI Specialty Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 07, 2013	CPT Code 99455-V5	$278.71	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.

   (B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

   (3) The following applies for billing and reimbursement of an MMI evaluation.

   (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

   (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

   (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

   Review of requestors submitted documentation finds DWC-69 which indicates in section three of the form the claimant has reached clinical maximum medical improvement on August 07, 2013 and section four box A is marked which states "I certify that the employee does not have any permanent impairment as a result of the compensable injury." In further review of the report provided by the examining doctor the report indicates the issues addressed were maximum medical improvement and impairment rating if any. The examining doctor indicated in the report that the claimant was at clinical MMI and ongoing objective exam findings do not warrant a permanent impairment. Review of the medical bills provided for services on August 07, 2013 the examining doctor billed with CPT Code 99455-V4 in the amount of $500.00 with one unit. The total MAR for the services performed on August 07, 2013 is $221.29.

   The respondent issued payment in the amount of $221.29. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/27/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.